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A NEW JOURNAL OF OBSTETRICS AND GYNÆCOLOGY,

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THE OBSTETRICAL JOURNAL

OF GREAT BRITAIN AND IRELAND,

INCLUDING MIDWIFERY AND THE DISEASES OF WOMEN AND CHILDREN.

WITH AN AMERICAN SUPPLEMENT,

EDITED by W. F. JENKS, M.D.,
Surgeon to the State Hospital for Women, Philadelphia.

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OBSTETRICAL JOURNAL OF GREAT BRITAIN AND IRELAND.

AMERICAN SUPPLEMENT.

FOR APRIL, 1875.

Original Communications.

Clinical Observations on the Use of Pessaries in the Early Months of Pregnancy.

By Albert H. Smith, M.D., President of the Obstetrical Society of Philadelphia.

While the subject of retroversion of the gravid uterus as an accident of pregnancy, attended with the serious and even in some cases fatal results consequent upon it, at an advanced period of gestation, has been thoroughly studied and discussed, the influence of previously existing displacements upon the retaining capacity of the uterus in the early months seems to have been overlooked, or at least only vaguely suggested, until attention was called to it by Dr. Phillips, in the Obstetrical Transactions of the London Society, in his interesting paper on "Retroflexion as a Cause of Abortion."[1] No doubt most obstetricians and gynecologists having any extended field of observation had noticed the relation existing between habitual abortion and uterine maladies, but no author had before definitely laid down the displacements of the womb as a positive prevention of the development of the ovum.

While recognizing the services of Dr. Phillips in directing attention to this important subject, and making valuable suggestions as to the prevention of the accident when arising from such a cause, I must differ from him as to the exact nature of the uterine deviation which is likely to give rise to abortion. "Retroflexion," which he describes as the condition found in his cases, is not, in my opinion, either from theoretical probabilities or from practical observation, likely to be the condition present in habitual abortion. A flexion of the uterus, being in its strict sense a bending of the axis of the womb at or near the union of the body with the anatomical neck, must, to a certain extent in all cases, and positively in women who have never before been pregnant, be attended with a deficiency in the calibre of the

[1] Vol. xiv. p. 45.

canal at the point of flexion. As a result of this condition, there must be a mechanical obstruction to the passage of fluids in either direction; hence, we have dysmenorrhea and sterility as constant attendants upon flexions of the uterus of whatever sort. And I may say that in my experience, either in private or public practice, I have never found a woman with a uterine flexion as a condition existing previous to marriage who had not decided dysmenorrhea, or who became pregnant until her flexion was rectified by mechanical means, either by straightening out with sounds or dilators, or more frequently by raising from the floor of the pelvis by properly constructed pessaries. If, however, a woman with such flexion should have had her cervical canal dilated before by parturition, or, as a virgin, should fortunately have had a canal large enough not to be obstructed by the flexion, and should become pregnant, I can see nothing in the essential nature of that deviation to interfere with her retaining her ovum, unless the flexion be at the same time complicated with a retroversion, which is by no means a necessary complication, as flexions of the uterus are constantly found when the axis of the body of the organ maintains its proper relation to the axis of the pelvis. In a simple flexion the deviation is at a point below the cavity containing the developing ovum, and can scarcely possibly interfere with its mechanical or physiological enlargement under the steadily increasing stimulus of pregnancy; and further, we would reasonably expect that when a retroflexed uterus became occupied with an ovum, the gradual enlargement of the body would steadily and easily overcome the faulty relation without in any way diminishing its retentive power.

In a retroversion, however, we have a very different state of things; the patulousness of the os and cervix are not in any way interfered with, there is no obstruction either to the exit of the menses or to the entrance of the seminal fluid; therefore, we have not in this displacement either dysmenorrhea or sterility, unless the case be complicated with inflammatory action, when we might have the former as a congestive condition, and the latter from occlusion of the cervix by plugs of viscid mucus. When the uterus becomes impregnated then we have again a different result from that of retroflexion; the uterus being in an unnatural position with relation to the pelvic

organs, and being pressed downward and backward by the superincumbent mass of the intestines, operated upon not only by their weight but by the tonic contractions of the abdominal muscles; its fundus thrust back toward the sacrum; its ligamentous attachments, instead of holding it suspended firmly and sustaining it with a mobility just sufficient to accommodate it to the unavoidable movements of the body, now relaxed and useless, allowing it to be jostled rudely about, and irritated by every change in the relation of the surrounding organs; in such a condition of things the retentive power of the uterus must be stronger than it usually is in a primiparous woman to continue its development, resisting the influences which from the first operate to set up an irritability in its tissues, and later, as its enlargement goes on, forcing its fundus gradually upward along the sacral curve, and overcoming the many hindrances to its ascent into the upper pelvis. If the true pelvis be specially roomy, or the hollow of the sacrum unusually developed, then we have the growth of the uterus much more easy up to the point at which it becomes impacted in the pelvis, and being now too large to get through the superior strait it calls attention to the alarming situation by the pressure upon the bladder of its lower segment. Its cervix is now retroflexed truly; because, being bound down toward the anterior pelvic wall, and at the same time forced upward by the mass of the enlarging womb, it can only accommodate itself to the condition by bending at an acute angle to the body far up behind the pubic bone. Here then we have the well-known and long-recognized malady described exclusively as retroversion of the gravid uterus; and yet, as we have seen, only an aggravated form of what has existed from the outset of pregnancy, only allowed to run on to such a period of gestation by the peculiar anatomy of the pelvic canal.

That uterine displacements are often, very often, complicated with cervical inflammation and endometritis, holding to these diseases the relation of an effect to a cause, and that in such cases if pregnancy is not impossible (which it no doubt frequently is) abortion will recur as regularly as the womb is impregnated, I am quite ready to admit, as well as that patients so affected can only be relieved from habitual abortion by treatment directed to the inflamed uterus, the displacement disappearing as its cause is removed. But I cannot agree with Dr. Barnes that

pure and uncomplicated cases of displacement are so very rare. I have seen very many of them presenting in young married women, and resulting in abortion, or, in some cases, when the retroversion was very marked and the cervix forced upward behind the pubis, in sterility; both conditions persisting until the displacement was rectified by mechanical support long enough to enable pregnancy to advance beyond the fourth month; cases in which no sign of uterine disease had ever been present, or any disability had drawn attention to the organ other than these evidences developed by married life. Out of the whole number of such patients whom I have seen during my professional life, I select three illustrative cases, all of which have occurred to me during the past year.

Case I. Mrs. L., aged 21 years, had been married one year, during which time she had two abortions at three months each. Previously to her marriage she had been in absolutely robust health, having never been sick in bed a day since her early childhood; had had no irregularity of menstruation, either as to time, quantity, or pain; had never had any disability except that from about fourteen years of age she instinctively avoided carriage riding or horseback exercise, from a little discomfort in her sacral region which attended these modes of travel; but as a walker she was rather noted among her acquaintances, and could dance or run with entire freedom from pain; had never had any leucorrhœa. The abortions had resulted from no appreciable imprudence or accident of any kind. Her second abortion produced intense moral depression, and she placed herself under my care in reference to a prevention of a return of the trouble. On examination I found the uterus completely involuted with a very marked retroversion; the fundus rested in the hollow of the sacrum, while the os pointed toward the pubic arch; there was no engorgement or tenderness of the womb; the cervix was soft, of normal size, and its mucous membrane perfectly healthy. There was no flexion. I introduced a lever pessary, modified from Hodge; in eight months she again became pregnant; caution was insisted upon as to her abstinence from any active exertion during her early months, and absolute rest during the week of every month when she would have a return of her ovular excitement. She passed without any threatening of trouble to the fifth month of gesta-

tion, when the uterus being well supported by the pelvic brim I removed the pessary, and she was delivered in October last of a living child. After the introduction of the pessary, the symptom of displacement which had prevented certain kinds of exercise disappeared, and for the first time since childhood she could enjoy driving, either in a light or heavy carriage.

Case II. Mrs. H., aged 22 years, had been married eighteen months when I was called upon to take charge of her in her third abortion, she being then about three months pregnant. This was in February, 1873; she had no trouble after her abortion, and feeling so perfectly free from any symptom of local trouble, attributing her misfortune to some over-exertion, my suggestion as to the necessity of investigating her case was not accepted. In May she passed her catamenial period without any show. Symptoms of pregnancy being decided, I placed her in bed, and kept her at absolute rest during the week of each month, allowing no more liberty than a reclining position on a couch in the interval. In July signs of abortion came on suddenly, preceded by some pelvic fulness and discomfort, and, in spite of every effort to prevent it, she expelled her fetus at about three months and one week. She recovered well from this abortion, spent a few months in travelling, and on her return to the city in October I insisted upon her having an examination as to the condition of her uterus. Being greatly disappointed in her past failures, she was quite willing. I found a marked retroversion of an otherwise perfectly normal uterus, no flexion, no inflammatory symptoms; she had not at this time, nor had she had previously at any time of her life, any discomfort or disability from her pelvic organs; was a woman of remarkable vigor and blooming health; very active in her habits, a great walker, and enjoying driving and horseback riding without restraint. I introduced a lever pessary, which she wore without any consciousness of its presence, as she had before no feeling of its need. In November she again became pregnant; I made no restriction upon her habits except during the week of each month, then requiring her simply to keep her room. She passed the usual period of trouble without a symptom, the pessary was removed at five months, and she was confined after one hour's labor of a fine child in the following July of last year.

Case III. Mrs. K., aged 26 years, married in May, 1873; had had some pain from her catamenia before marriage, but perfectly healthy otherwise. Became pregnant in October, had some pelvic distress from the end of the second month, began to have hemorrhage at three months, lasting a week, when she sent for me to relieve her from a partially completed abortion. I found a very marked retroversion, without flexion, in removing the ovum, and after her recovery suggested the necessity of rectifying it, but she felt so entirely free from any inconvenience or sign of disease that my advice was not acted upon. In March, 1874, she again became pregnant; at two and a half months she developed the same sense of pelvic fulness and distress as before; at three months a slight show made its appearance, attended with greatly increasing pain in the hypogastrium and sacral region; I insisted upon an examination; found a marked retroversion, introduced a lever pessary, which gave her *instantaneous* relief, to her great astonishment; the rise of the fundus in the axis of the pelvic brim being followed by the immediate subsidence of her pain and the arrest of her bleeding. She kept her bed for a few days, but after that exercised without any restriction, ten days after the reposition going with a party of her friends to the seashore. After five months I removed the pessary, and she was confined in December, 1874, of a living child. As may be here mentioned of the other two cases, she was kept on her couch without resting upon her feet for three weeks after her delivery, and, with the same results as they, has had no symptoms of any uterine trouble. This rule, which I insist upon with the happiest effects in all cases of labor, I enforce with special earnestness when there has been any evidence of displacement or inflammation before the occurrence of pregnancy; believing as I do that it is of the utmost importance that the weight of the uterus should not be brought to bear upon relaxed ligaments until the organ has fully completed its involution.

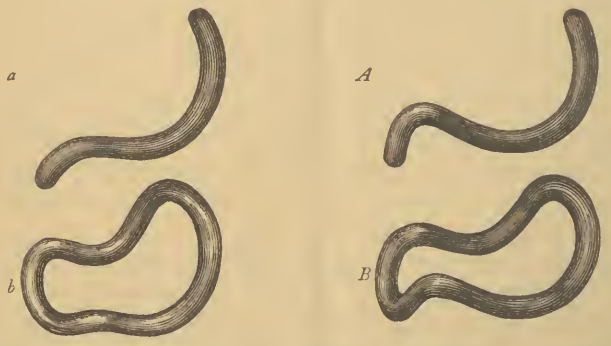
Here then are three cases, each one illustrating a peculiar point in reference to the subject of this paper. *Case I.* simply proves the influence of retroversion in causing abortion, and the successful effort at prevention by the use of the pessary. *Case II.* proves, in addition, that mere rest upon the back, though maintained absolutely, failed to do what the reposition of the organ

accomplished easily, with scarcely any restriction upon the ordinary habits of life. *Case III.* still further gains upon the other two in solving the problem of Dr. Phillips in his paper, as to what we are to do when impregnation has already occurred before reposition has been effected. When the condition is recognized, and we have reason to fear its results if not remedied, or even, as in the case reported, if positive symptoms have developed of an effort on the part of the uterus to rid itself of the ovum, why should we hesitate about replacing the organ, and retaining it in place by an instrument so absolutely innocent and free from possible objection as a properly constructed pessary? I have raised in two instances the retroverted uterus of four to five months' gestation, impacted in the pelvis, by gradual pressure of a colpeurynter, without disturbing the relation of the ovum; surely there can be no risk in gently raising a uterus of three months or less, moving as it then does freely in the pelvis.

In this connection I may be allowed briefly to refer to the pessary which for twelve years past I have used with so much satisfaction, and which many of my friends have adopted in preference to any other in the relief of retroversions. Very early in my connection with the Clinic of the Philadelphia Lying-in Charity as assistant-physician, I became satisfied that there was a great desideratum in a properly constructed pessary, one which would keep the uterus in position and yet be perfectly comfortable to the patient, in short, one which would do its work without giving rise to any consciousness of its presence. The ball and disk, without keeping the uterus in normal position, aggravated cervical inflammation by constant pressure upon the inflamed tissues; the elastic ring, while applicable to a few cases, required too violent tension of the vaginal attachments of the cervix, and by long-continued pressure caused vaginal ulceration, in some instances embedding itself in the vaginal walls. The India-rubber air pessaries were filthy, and the numerous stem and other complicated contrivances had objections so obvious that they need not be mentioned.

The lever principle of my old teacher, the late Dr. Hodge, was clearly the correct and only scientific one, the instrument getting its support from the floor of the pelvis, allowing free natural movement to the womb, and making no pressure upon the cervix. But practically his pessary was a failure; very few

patients could tolerate its presence. The open end of the horse-shoe pattern ulcerated the anterior wall of the vagina; the closed lever with its rectangular, almost square, form could not be kept in place, working round gradually until one of the angles rested against the neck of the bladder, the uterus hanging over the concavity of the lateral portion; if it maintained its position the straight bar in front pressed against the urethra, causing vesical tenesmus and strangury or retention. The modification which I decided upon, and which has given me entire satisfaction since, consisted in the following changes. I lengthened the closed lever so that its length is about twice its width; I changed the rectangular form into an ovoidal, with the lesser extremity in front; I made a curve from above downward in the anterior bar, and curved upward somewhat the flat posterior bar. By these changes I have the pessary easily retained in place, its length and ovoidal form adapting it to the shape of the vagina, which is conoidal, with its base toward the vaginal cul-de-sac, while on the contrary the rectangular or square pessary cannot be accommodated and retained steadily in such a cavity, but easily and almost necessarily works out of position; the curvature of the posterior bar upward takes away the sharp angles behind, and the centre of the bar resting directly behind the lower portion of the body of the uterus allows it to hang over it suspended by its vaginal attachment without any undue pressure upon the vaginal tissues, as will result from the use of the straight bar. The depression of the anterior bar gives a rounding off to the corners which rest against the vagina, and removes



all pressure from the urethra, a matter of immense importance, upon which depends the ability of many patients to tolerate the

pessary at all. The accompanying cuts show as well as any diagram can the modification: *a* and *b* representing a lateral and oblique view of the original Hodge pessary, and *A* and *B* the corresponding view of my modification.

It is impossible in a diagram clearly to show the difference, although the engraver in this instance has done pretty well; it, however, fails to give an idea of the rectangular form of the original Hodge lever with its parallel sides and square angles.

With the general introduction of the lever pessary, the prejudice against its use is gradually being driven out of the minds of regular practitioners of medicine, who, conscientiously studying the pathological conditions and therapeutical indications of uterine diseases, are compelled to recognize it as a legitimate and necessary means of treating cases of simple displacement and of inflammation of the neck or body of the uterus, where the organ requires temporary support, for the same reasons as does any other inflamed pendulous organ in the human body.

The merits which I would claim for the lever pessary are its general facility of introduction; its deriving its support from the floor of the pelvis, making no tension of the vaginal tissues in retaining its place, producing its effect as a true lever, the fulcrum being upon the pelvic floor, the weight resting on the short arm being the body of the uterus, and the power acting on the long arm being the elasticity of the anterior vaginal wall, the weight of the intestines and the action of the abdominal muscles, these two latter forces, which would operate upon the displaced uterus to keep it displaced, now being utilized by the presence of the pessary to elevate it; preserving the natural mobility of the uterus; making no pressure upon the neck, so generally the seat of inflammatory tenderness; acting without consciousness upon the part of the patient, and, so far from interfering with the functions of reproduction, acting, as this paper is written to show, as an indispensable aid in many cases to the successful carrying on of that process.

In connection with the subject of the use of pessaries in the early months of pregnancy, I may refer to a point of clinical experience which has presented itself too frequently I think to be a mere coincidence. When patients who have previously had children have become pregnant while wearing pessaries they have observed and called my attention to the fact that the

symptomatic nausea has been greatly diminished, and in some cases I have been especially surprised at the vast difference in the condition of the patient in this respect from that of previous pregnancies. The value of the pessary as a means of diminishing this distressing and sometimes alarming symptom, is a subject which will call for some future clinical study.

Monthly Summary.

MIDWIFERY.

The Management of Head-last Labors.—We abstract the following from a paper read before the Philadelphia County Medical Society by Prof. William Goodell, M.D., and published in the *Phila. Med. Times* of March 20, 1875 :—

The objects of this paper are to search out the best means for shortening the duration of labors in which the head is born last, for preventing the death of the child, and, as a conjoint consequence, for giving the physician a greater confidence at the bedside of his patient.

For shortening the first stage of head-last labors the author recommends the hydrate of chloral. Given every half-hour in doses of from ten to fifteen grains, it promptly relaxes the most rigid cervix. Artificial rupture of the membranes must not be resorted to until the os is fully and wholly dilated. If, after the completion of the first stage of labor, there is delay in the engagement of the breech, one foot should be brought down, and preferably the one nearer to the pubic arch. This lessens the size of the breech, and puts the further progress of the labor under the control of the physician. No further traction on the leg should be made unless loudly called for, and then only during a pain, lest the arms should become extended. The pain that delivers the breech should be supplemented by traction, or by propulsion on the cranial vault, through the supra-pubic abdominal wall, so that the arms and the shoulders may also be expelled at the same time.

After the birth of the breech there must be no delay on the part of the physician in completing the delivery. Delay here means death. One of five minutes is usually fatal. The woman should be exhorted to bear down; but if her efforts prove unavailing the physician must at once proceed to deliver her. If the arms be extended, he must immediately bring them down, even at the risk of a fracture. The bone which usually snaps is the clavicle of the pubic shoulder; but it readily heals without